STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#2	445071	A. BUILDING _____ B. WING _____	01/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY NURSING HOME	1650 OLD KNOXVILLE ROAD TAZEWELL, TN 37879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to assess two (#86, #3) of five residents reviewed for self-administration of medications. The findings included: Resident #86 was admitted to the facility on June 12, 2014, with diagnoses including Chronic Obstruction Asthma and Chronic Obstructive Pulmonary Disease. Observation during a medication administration pass on January 5, 2015, at 9:30 a.m., revealed Licensed Practical Nurse (LPN) #1 was administering medications to resident #86. Continued observation revealed the LPN handed a Flo Vent Diskus Aerosol inhaler to the resident to self-administer. Further observation revealed the resident self-administered the medication by inhaling one puff. Medical record review of a physician's order dated January 1, 2015, revealed, "Flovent Diskus Aerosol 250 mg (milligram) 1 puff inhale orally two times a day." Continued review revealed no physician's order to self-administer medications. Further medical record review revealed no assessment for self-administration of medications	F 176	F176 Resident's # 86 and #3 identified in the deficient practice of self-administration of medication, without documented education and competency have now been educated upon physician order. They have also completed the self-administration form assessment by the RN. Both Resident #83 and #3 were successful in meeting the criteria and demonstrating competency for self administration of the inhalers. The RN was responsible, and this was completed 01/05/2015. The Director of Nurses was responsible. The licensed nursing staff members identified in the deficient practice were educated on the importance of compliance with facility all policies and procedures with emphasis placed on Medication Self-Administration. The Director of Nurses was responsible. 100% of the licensed nursing staff will be educated on the importance of compliance with facility policies and procedures with emphasis on	1/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-9-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1 had been completed. Resident #3 was admitted to the facility on November 19, 2012, with diagnoses including Allergic Rhinitis (Cause Unspecified), Diabetes, and Hypertension. Observation during a medication administration pass on January 5, 2015, at 9:40 a.m., revealed LPN #2 was administering medications to the resident. Continued observation revealed LPN #2 handed the resident the nose spray Flonase to self-administer. Further observation revealed the resident attempted three sprays to one nostril. Continued observation revealed the nurse at that time took the medication and administered one puff to the other nostril. Medical record review of a physician's order dated December 15, 2014, revealed, "Flonase 1 spray in both nostrils one time a day." Continued review revealed no physician's order to self-administer medications. Further medical record review revealed no assessment for self-administration of medications had been completed. Review of the facility's policy Self Administration of Drugs revealed, "Upon order of the attending physician and resident's request for self-administration of medication...the interdisciplinary team will start the evaluation process...If the evaluation indicates the resident is able to self-administer, such will be entered into the resident's care plan...The physician's order sheet will state when and which medications will be self-administered by the resident." Interview with the Director of Nursing on January	F 176	the Medication Self-Administration. The process will be reviewed, (a) the nurse will obtain the PCP order for resident to self-administer medication (b) the nurse will then complete the staff administration form for each applicable resident then (c) approval or disapproval of criteria based results will be documented to establish competency. Attendance of education session will be verified by participants signature on the "Sign-in sheet." The RN Charge Nurse is responsible for oversight of this process. The Director of Nurses is responsible. 100% of the current resident's that have orders for hand-held nebulizer treatments, nasal spray, inhaler, and eye drops will be screened for ability to self-administer listed medications, if they want to. Newly admitted Residents and Residents receiving new orders for the above listed medications will be screened upon admission and upon receipt of the new order. A physician's order will be obtained for appropriate "candidates." The appropriate Residents will receive education and the nurse will complete the Self	

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F 176	Continued From page 2 6, 2015, at 3:30 p.m., in the conference room, confirmed residents' #86 and #3 had not been assessed to self-administer medications and physician's orders had not been obtained for self-administration of medications.	F 176	Date of completion 01/31/2015.	1/31/15
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to follow the care plan for one resident (#115) of thirty residents reviewed. The findings included: Resident #115 was admitted to the facility on September 3, 2014, for diagnoses including Chronic Respiratory Failure, Muscle Weakness, Cerebrovascular Disease, Abnormal Involuntary Movements, and Rehabilitation. Medical record review of a physician's recapitulation order dated December 2014, revealed, "...fallen star program RSD [resident] to wear red non skid socks when not wearing regular shoes..." Medical record review of a fall risk assessment	F.282	F282 Immediately upon identification and notification of the deficient practice involving Resident #115, the non-compliant safety footwear was removed and the appropriate, as per careplan, red non-skid footwear was applied and all Fallen Star residents were checked. The RN Charge Nurse was responsible for immediate corrective action. The direct care staff members that were identified as involved in the deficient practice were educated by the Director of Nurses regarding the importance of compliance with facility policy and procedures, safety actions and individual resident careplans. The Fallen Star program was discussed emphasizing the use of red non-skid socks when not wearing regular shoes and the individual Resident's careplan. The Director of Nurses is responsible. 100% of Residents will be reviewed for orders to have red non-skid	

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F 282	Continued From page 3 dated December 3, 2014, revealed Resident #115 scored a 12, indicating the resident was at high risk for falls. Medical record review of the resident's care plan, last revised December 15, 2014, revealed, "...fallen star program...red non skid socks when not wearing regular shoes..." Review of facility policy Falling Star Program, last revised on May, 2008, revealed, "...residents who have a history of frequent falls or have high risk factors for falling will be identified...plan of care shall be updated with the plan that is being used to prevent falls...when resident is out of room non-skid red socks will be on resident for high visibility to enhance staff awareness...will alert all staff of the potential for falls..." Observation on January 7, 2015, at 9:17 a.m., revealed Resident #115 was sitting in a chair in the second floor day room. Continued observation revealed the resident was wearing blue and pink striped fuzzy socks and no shoes. Interview with Licensed Practical Nurse (LPN) #3 on January 7, 2015, at 9:24 a.m., at the second floor nurses station, revealed, "...fallen star program means...wear red socks with tread on them when they aren't wearing shoes...that way we know they are a falls risk..." Observation and interview with LPN #3 on January 7, 2015, at 9:30 a.m., in the second floor day room, confirmed the resident was not wearing red non-skid socks and "she should be."	F 282	socks and then checked to make sure the appropriate socks are on. A list of Residents ordered red socks safety intervention will be made by the RN Charge Nurse and submitted to the Director of Nurses. When the Care Plan Team initiate or discontinue this intervention, one member of this team will update the red socks list, that will be posted at each nurses station and with the Director of Nurses. 100% of residents with orders for red socks will be checked for appropriate socks being on the resident during each 2 hour rounds by the CNA's. Any violation of order is to be corrected immediately and reported to the Charge Nurse. The Charge Nurse report verifying compliance with red non-skid socks will be reviewed by the Director of Nurses or designee on a daily basis. The total # of Resident's with red socks non-skid socks on / the total # of Resident's with orders for non-skid red socks = Rate of compliance. Compliance is expected to be 100%. Results from this audit will be presented to the Administrator, Medical Director and Quality Management Committee on a monthly basis by the Director of Nurses until a compliance rate	

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F 329 F 329 SS=D	Continued From page 4 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of the Psychiatric Consultation, and interview, the facility failed to attempt a gradual dose reduction of an antipsychotic medication for one resident (#46) of five residents reviewed for unnecessary medications. The findings included:	F 329 F 329	F329 Resident # 46, who was identified in this deficient practice, primary care physician ordered-after staff education, (on 01/09/2015) another psychiatric evaluation for a second opinion to reduce or discontinue Seroquel 25mg before ordering the medication change. This evaluation was completed 01/15/2015 with the same recommendation received. The Resident's physician was notified of the evaluation and recommendation on 01/15/2015 and an order was received to discontinue the Seroquel 25mg. The pharmacist is responsible for education of the physician and clinical staff. The Director of Nurses is responsible . 100% of all current residents seen by the psychiatric provider have been reviewed and no further recommendations were missed. The Director of Nurses was responsible for organizing and coordinating the chart review. Physician and staff education to be provided education stressing the need for evaluation and reevaluation	

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F 329	Continued From page 5 Resident #46 was admitted to the facility on June 29, 2012, with diagnoses including Alzheimer's Disease, Dementia, Psychosis NOS (Not Otherwise Specified), Depression, Anxiety Disorder, and Dysphagia. Observation on January 5, 2015, at 3:00 p.m., revealed resident #46 sleeping in bed with a tube feeding infusing via a feeding pump at 50 milliliters per hour. Medical record review of the Psychiatric Progress Note dated September 18, 2014, revealed, "...staff report patient is cooperative with care...no aggression...advanced Alzheimer's Disease...no problems with sleep...no new or worsening anxious or agitated behaviors...Recommendations: 1. ...Consider discontinue Seroquel...Mood and Behaviors are stable..." Medical record review of a Quarterly Minimum Data Set (MDS) dated October 8, 2014, revealed the resident had severe cognitive impairment and was totally dependent for all Activities of Daily Living (ADLs). Medical record review of the Order Summary Report for January 2015 revealed the resident received Seroquel 25 (an antipsychotic medication) one tablet via the PEG-Tube (percutaneous esophageal gastric feeding tube) at bedtime each day. Interview with the Director of Nurses (DON) on January 7, 2015, at 8:40 a.m., outside of the DON's office, revealed the MDS Coordinator received a list each month of residents on	F 329	of Residents on psychiatric medications. Physician education to be documented in the Resident record by the entity providing the education. Staff signatures on the attendance sheet will validate attendance. The Pharmacist is responsible. The PPS Coordinator maintains a list of all Residents to be seen by Psychiatric consult services, including new referrals and follow ups. Upon completion of psychiatric consult recommendations are given to the PPS coordinator, who reviews the recommendations and provides this information to the Charge Nurse to contact the PCP's for approval order(s). The recommendation(s) for the Resident will then be faxed to the PCP office for their records. The Total # of psychiatric medication recommendations approved and ordered by the PCP / the total # of psychiatric medications recommended by the consulting psychiatric provider = Rate of compliance. Expected compliance expected is 100%. The PPS Coordinator will aggregate this data and submit it monthly to the Director of Nurses or designee, who will review and present the data to	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 6 psychoactive drugs and was responsible to coordinate gradual dose reductions. Interview with the MDS Coordinator on January 7, 2015, at 9:43 a.m., in the nursing station, confirmed the resident had continued on the same dose of Seroquel for twelve months; the nursing staff had not recorded any behaviors during the previous five months; the MDS Coordinator had no knowledge of behaviors related to the resident's diagnosis of Dementia with Psychosis; and the facility failed to attempt a gradual dose reduction of the resident's antipsychotic medication.	F 329	the Administrator, Medical Director and Quality Management Committee monthly. Monthly monitoring will continue until a compliance rate of 100% is achieved and sustained for three consecutive months. The Director of Nurses is responsible. Date of Completion: 01/31/2015	1/31/2015